

State of Alaska
Department of Health & Social Services
Division of Health Care Services
Certification & Licensing

Primary Physician's Statement
AS 47.33.230(c)(2)

Date_____

Residents Name_____

Primary Physician Name_____

1. Medical History_____

2. Physical Examination
(not older than six months from date resident moves into Assisted Living Home)

3. Listing of Resident's Complete Current Medication Regimen_____

4. Statement Of Current Therapy Regimen Necessary To Maintain Or Increase The Resident's Functioning, Mobility, Or Independence _____

Primary Physician's Signature _____